ARIZONA INFANT DEATH INVESTIGATION CHECKLIST

Scene Investigated by _____**Agency** _____**Phone Number** _____ **County** _____

A. General Information

1. Infant's name _____ Sex _____ Age _____ Date of birth _____
2. Date of death _____ Time of death _____AM/PM Location _____
3. Father's name _____ Age _____ Occupation _____
4. Mother's name _____ Age _____ Occupation _____
5. Are there siblings? □ Yes, □ No If yes, list ages _____
6. Home address (if different from location of death) _____
7. Pediatrician (family physician) _____ Physician's Phone _____

B. Past History

1. Birth weight _____lbs _____oz Was infant premature? □ Yes, □ No If yes, number of weeks premature _____
2. Place of Birth (Hospital and City/State) _____
3. Any problems with pregnancy and delivery? □ Yes, □ No If yes, explain _____
4. During pregnancy, did anyone: □ Smoke? Who? _____ □ Use drugs? Who? _____What? _____
5. Has infant ever required hospitalization or emergency care? □ Yes, □ No If yes, explain: When? _____
   Where? _____, Why? _____
6. Anything unusual about sleeping habits or breathing? □ Yes, □ No Has infant turned blue or stopped breathing? □ Yes, □ No
   Has infant had seizures or convulsions? □ Yes, □ No If yes, explain _____
7. Any other medical problems or concerns? □ Yes, □ No If yes, explain _____
8. Has infant been immunized? □ Yes, □ No If yes, are immunizations up to date? □ Yes, □ No, □ Unknown Date of last immunization _____
9. Have there been other child deaths in this family or relatives of the immediate family? □ Yes, □ No If yes, where? _____
   Cause of death(s)_____ Age(s) at death _____

C. Recent History

1. Was the infant □ Breast-fed □ Bottle-fed □ Both? Last feeding _____AM/PM What was last feeding? _____
2. Recent illness? □ Yes, □ No If yes, what? □ Appetite change, □ Cough, □ Diarrhea, □ Ear infection, □ Fever, □ Irritability/listlessness, □ Sniffles, □ Vomiting, □ Weakness/ "floppiness", □ Wheezing, □ Other _____
   Were medications or home remedies given? □ Yes, □ No If yes, what _____* Amount_____ Time _____ AM/PM
3. Was there recent exposure to chemicals? □ Yes, □ No If yes, what _____ When _____
4. Is anybody in the house sick? □ Yes, □ No If yes, who _____ Illness_____
5. Was there a history of a recent fall or injury? □ Yes, □ No If yes, explain _____
6. Was the infant in anyone else's care in the last 48 hours? □ Yes, □ No If so, whom? _____
7. Last date infant was seen by a medical provider _____ Where? _____ Reason for visit _____

D. Scene

1. Last seen alive_____ AM/PM Was infant behaving normally? □ Yes, □ No If no, describe: _____
2. Who discovered the infant? Name_____ Relationship _____ Time _____AM/PM
3. Position infant was in when found? □ Abdomen, □ Back, □ Side Position when put to bed? □ Abdomen, □ Back, □ Side
   What was the infant wearing? _____ How was the infant covered? _____
4. Were the nose and mouth obstructed? □ Yes, □ No If yes, with or by what? _____
5. Describe infant's sleeping environment □ Crib, □ Bed, □ Sofa, □ Other _____ Type of mattress □ Soft, □ Hard, □ Waterbed, □ Exposed plastic covering Were any of the following found in infant's bed? □ Pillow, □ Blankets, □ Cushions, □ Toys, □ Pets, □ Other_____ Temperature of room _____
6. Was the infant sleeping alone? □ Yes, □ No If no, with whom? □ Child, □ Adult, □ More than one person Estimated weight of sleeper(s)_____ Drug or alcohol used? □ Yes, □ No If yes, what? _____
7. Was the infant □ Warm, □ Cool
8. Were attempts made to revive the infant? □ Yes, □ No If yes, by whom? _____ Time of attempt _____AM/PM
   Method of attempt □ CPR, □ Shaken, □ Other_____
9. Does anyone in the immediate household or daycare facility smoke? □ Yes, □ No If yes, identify relationship _____

Comments: (Use this space to elaborate on questions above or to note anything unusual)

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*Use "Comments" section if more space is needed. Collect all medication/home remedy containers for submission to Medical Examiner.

White = First Responder Canary = Medical Examiner Pink = ADHS